Improving Chronic Care in the Indian Health Service

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Improving Chronic Illness Care
A national program of the Robert Wood Johnson Foundation

The Chronic Care Crisis

- **Escalating prevalence of chronic illness radically changing the work of medical care, especially primary care**
- **Clinical and behavioral management increasingly effective BUT increasingly complex**
- **Roughly 50% of Americans not receiving evidence-based chronic illness care (Quality Chasm)**
- **Unhappy clinicians leaving practice; medical trainees choosing other specialties**

Johns Hopkins U.S. Survey about Chronic Care: % Agreeing With

	Public	MD's	Policy-makers
People with chronic conditions usually receive **adequate** medical care	**48%**	**45%**	**22%**
Gov't programs are **adequate** to meet the needs of people with chronic conditions	**38%**	**20%**	**16%**
Health insurance pays for most of the services chronically ill people need	**37%**	**28%**	**23%**

Where we are in the U.S.

- **An acute care oriented medical care system that is not working for either patients or health professionals??**

The Evidence is Clear

To optimize clinical and health status in chronic disease, we must radically change delivery systems to assure:

- **Clinical management by evidence-based protocol,**
- **Ongoing support of patient self-management,**
- **Regular follow-up with assessment of severity, self-management and treatment, and**
- **Greater intensity of management for high risk patients.**

Two Questions

- **Do we know how to improve chronic illness care?**
- **Can busy primary care practices do it?**

Where to begin?

- **The scientific literature**

Randomized trials of system change interventions: Diabetes

Cochrane Collaborative Review and JAMA Re-review

- **About 40 studies, mostly randomized trials**
- **Interventions classified as decision support, delivery system design, information systems, or self-management support**
- **19 of 20 studies which included a self-management component improved care.**
- **All 5 studies with interventions in all four domains had positive impacts on patients**

Renders et al, Diabetes Care, 2001;24:1821
Bodenheimer, Wagner, Grumbach, JAMA 2002; 288:1910

Meta-analysis of Pre and Post-discharge Programs for Hospitalized CHF Patients

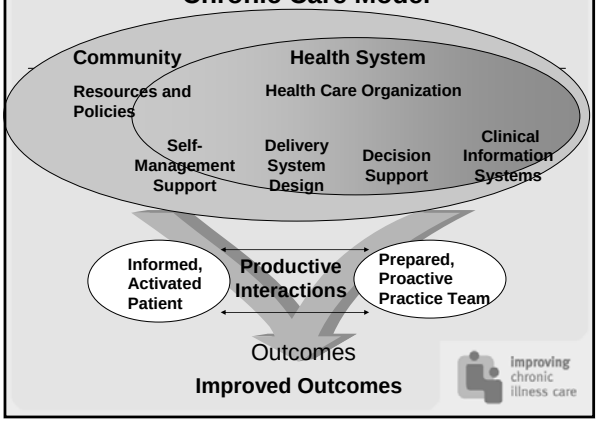
- **18 RCTS, Follow-up 3-12 months**
- **Care by team coordinated by nurse care manager, structured clinic or home visits plus phone,**
- **focus on medications and self-management**
- **25% reduction in readmission (43 to 35%)**
- **13% reduction in all-cause mortality**
- **Greater improvement in QOL**
- **Net cost savings $536 per month**

Phillips et al. JAMA 2004; 291: 1358

Chronic Care Model Development 1993 --

- **Group Health Cooperative is a medical group/ insurance plan serving 500,000 people**
- **Tested different approaches to diabetes improvement at Group Health Cooperative**
- **Care processes improved dramatically, pmpm costs fell 10%**
- **RWJF funds Improving Chronic Illness Care to study, implement, and disseminate Chronic Care Model**

Chronic Care Model



The Goal of System Changes are Productive Interactions

planned interactions
over time during which the critical clinical and behavioral elements of care are performed reliably

What characterizes an "informed, activated patient"?

Informed, Activated Patient

They have the motivation, information, skills, and confidence necessary to make good decisions about their health and to manage it

Self-management Support

What is self-management?

"The individual's ability to manage the symptoms, treatment, physical and social consequences and lifestyle changes inherent in living with a chronic condition."

•**NOT AN OPTION OR PREFERENCE**

Barlow et al, person Educ Couns 2002;48:177

Self-management Support

Every patient receives effective self-management interventions including ongoing collaborative goal-setting and problem solving.

Community Resources and Policies

Practice has linkages with community organizations that can enhance practice capabilities, provide key patient services, or improve care coordination.

For example: nurse care management for CHF patients in hospital

What characterizes a "prepared" practice team?

Prepared Practice Team

•Key care roles are assigned to team members

•Team trained for roles

•Team uses guidelines and patient data to plan and manage care for individual patients and practice

Delivery System Design

Practice team has defined roles, uses planned or structured visits to support evidence-based care, provides clinical care/case management when needed, and assures regular follow-up and care coordination

The Clinical Spectrum of Case/Care Management

Social worker — Nurse — Advanced practice nurse

Arranging social services	**Coordinating clinical and social services**	**Assessment, education, follow-up**	**Clinical therapy**

Diabetes

- Recent meta-analysis* found 15 studies of diabetes CM meeting quality criteria
- Most were conducted either in managed care or community clinics and were part of larger system changes
- HbA1c, BP, LDL improved in all studies where measured
- Average HbA1c reduction 0.5%

*Norris et al, Am J Prev Med 2002;22 (4S):15

Decision Support

Evidence-based guidelines are integrated into care, and supported by provider education, links with specialty expertise, and reminder and fail-safe systems.

Clinical Information System: Registry

A database of clinically useful and timely information on all patients provides reminders and feedback and facilitates care planning for individuals or populations.

Many electronic health records cannot do these things!

Health Care Organization

Organization and its leaders encourage and support better care using ongoing quality measurement, improvement & incentives.

Can Busy Practices Change in Accord with the CCM?

Chronic Conditions Breakthrough Series

- **One year collaborative quality improvement efforts involving multiple delivery systems and faculty**
- **Chronic Care Model guides comprehensive system change**
- **Practices use perfomance measurement and PDSA cycles to make changes to practice**
- **Over 1000 different health care organizations and various diseases involved to date**

RAND Evaluation of Chronic Care Collaboratives

- Studied 51 organizations in four different collaboratives, 2132 BTS patients, 1837 controls with diabetes, CHF, asthma
- CHF pilot patients more likely to be weighing themselves, more often on recommended therapy, had 35% fewer hospital days
- Asthma and diabetes pilot patients more likely to receive appropriate therapy.
- Asthma pilot patients had better Quality of Life
- Diabetes pilot patients had significant reductions in their risk of heart attack and stroke

Five year perspective: lessons learned

- Only reaching "early adopters"
- Practice redesign is very difficult in the absence of a larger, supportive "system"
- Smaller practices often need additional resources and help

King's Fund Study of Organizations with Best HEDIS Chronic Illness Scores

Organizational factors supportive of high quality chronic care:

- Strategic values and leadership that support long term investment in managing chronic diseases
- Well aligned goals between physicians and corporate managers
- Integration of primary and specialty care
- Investment in information technology systems and other infrastructure to support chronic care
- Use of performance measures and financial incentives to shape clinical behavior
- Use of explicit improvement model—usually the Chronic Care Model

What's needed to improve chronic illness care for the population?

- Leadership
- Standardized measurement
- Reduce financial disincentives, and consider adding incentives
- Infrastructure
  - Guidelines
  - Information Technology
  - Nurse Care management
  - Self-management Support
- Active program of practice change

Government funded health systems (so-called socialized medicine) lead the way!

- The IHS will join this group of best practices
- The VA, BPHC, and some public hospital systems are now national models
- One gets better care in a federally funded health care facility than in private practice
- It's a privilege to be working with you

Contact us:

•www.improvingchroniccare.org

thanks